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November 3, 2008

MEMORANDUM

TO:

Legislative Oversight Committee Members	Commission for MH/DD/SAS
Local CFAC Chairs	State CFAC
NC Council of Community Programs	NC Assoc. of County Commissioners
County Managers	County Board Chairs
State Facility Directors	LME Directors
LME Board Chairs	DHHS Division Directors
Advocacy Organizations	Provider Organizations
MH/DD/SAS Stakeholder Organizations	NC Assoc. of County DSS Directors

FROM: Tara Larson

Leza Wainwright

SUBJECT: Implementation Update #50

Submit CS Requests via ProviderConnect	Attestation Letters for False Claims Act
ValueOptions Customer Service	2008 CS Medicaid Audits
DMA Deferral of Remaining Rate Increases and TCM Rate Reduction	Accreditation Update
	CAP/ MR-DD Update

Submit Community Support Requests via ProviderConnect

Submitting Community Support requests to ValueOptions on the web via ProviderConnect is the most reliable method of submission. Submitting a request on ProviderConnect reduces the request turn around time by one to two days. Providers acquire an immediate confirmation of the request submission that can be printed for their records. Many of the largest providers in the state routinely use ProviderConnect with success. Yet, since announcing the availability of ProviderConnect in the April 7, 2008 Implementation Update #42, only 10% of Community Support requests are being submitted via ProviderConnect. Please email PSDProviderRelations@Valueoptions.com and sign up today for ProviderConnect training to improve your request management.

ValueOptions Customer Service

For faster service providers may wish to call ValueOptions customer service on a Thursday or Friday when call volumes are 30% less than other days of the week. Or an even more efficient option is to submit questions securely on-line via ProviderConnect for no hold time, 24/7 access, and a written reply from ValueOptions; providers can use the online customer service function of ProviderConnect even if the service request was not submitted online. In addition, questions can be submitted to customer service via ProviderConnect for all levels of care.

SFY 2008-09 Division of Medical Assistance Deferral of Remaining Rate Increases and Rate Reduction for Targeted Case Management

On October 9th, the Division of Medical Assistance issued a memo that addressed deferral of rate increases and a rate reduction for Targeted Case Management. As a result of the current forecast of declining revenue, the Division of Medical Assistance (DMA) is required to implement all measures within its control to achieve fiscal responsibility. With such direction, it is necessary to defer any rate increase allowed by SL 2008-107(HB 2436) that have not been implemented. In addition, the rate of reimbursement for Targeted Case Management (H1017 HI) will be reduced:

- **Deferral of the remaining inflationary adjustments allowed by SL 2008-107 (HB 2436):**
  This deferral of inflationary adjustment is for all providers except those exempted in the Conference Report, Section G, item 65. DMA will continue implementing the nursing home rebasing that occurred October 1, 2008; however, the inflationary component will be included in this deferment. This deferral affects those providers having rate adjustments with an effective date of October 1st and after, as well as any providers with a prior effective date but for which their new rates have not been activated in the payment system.

  Providers whose inflationary increases were loaded into the EDS payment system prior to an October 1st effective date will receive the rate increase.

  The providers impacted by this inflationary deferral are: hospitals, nursing homes, ICF-MRs non-state owned, physicians, dental, optical, chiropractors, podiatrists, local management entities, lab & xray, ambulance, hearing aid, personal care – community and adult care homes, all CAP programs, practitioners – non physician, high risk intervention, hospice and ambulatory surgical centers.

  The deferred adjustment is projected through June 1, 2009, at which time, state funding availability will be re-evaluated.

- **Adjustment to the Targeted Case Management rate currently paid to Local Management Agencies and Children Developmental Service Agencies**. Currently, DMA has a state plan amendment (SPA) at Center for Medicare and Medicaid Service (CMS) which is under consideration. During our discussions with them, CMS has required a payment rate methodology which is consistent with their approval of a case management SPA in another state. We have applied this methodology to our current service and adjusted the rate in accordance to their rate methodology. Targeted Case Management, Code T1017 HI, will have its rate adjusted to meet CMS's approved methodology. The rate adjustment will be effective January 1, 2009 and the new rate will be $14.59. If any additional rate methodologies are required by CMS, further rate modifications may occur.

We have received many questions and comments regarding the Targeted Case Management reduction. We must emphasize that the rate reduction is based upon the application of the rate methodology required by CMS. We will continue to work with CMS regarding the rate as well as the workgroup convened to discuss the impact of the reduction.

We regret that due to the current budgetary concerns that this is necessary. We appreciate your cooperation and we will continue to monitor the situation as the fiscal year progresses and let you know of any changes. Please direct any questions you might have concerning this memo to Roger Barnes, Assistant Director of Finance Management at 919-855-4190.

Submission of Attestation Letters for False Claim Act

Section 6023 of the Deficit Reduction Act (DRA) of 2005 requires providers receiving annual Medicaid payments of five million or more to educate employees, contractors, and agents about Federal and State fraud and false claims laws and the whistleblower protections available under those laws.

Beginning September 2007 and annually thereafter, DMA will notify providers that they received a minimum of five million dollars in Medicaid payments during the last federal fiscal year and that they must submit a Letter of Attestation to show that they are in compliance with the DRA. This minimum amount may have been paid to one North Carolina Medicaid provider number or to multiple provider numbers associated with the same tax identification number. Each Medicaid provider who receives a notification must sign and submit the Letter of Attestation to EDS within 30 days of the date of notification. Providers meeting the above requirement received a letter from DMA dated September 12, 2008.

Compliance with Section 6023 of the DRA is a condition of receiving Medicaid payments. Medicaid payments will be denied for providers that do not submit a signed Letter of Attestation within 30 days of the date of notification. Denied claims may be resubmitted by the provider once Medicaid has received the Letter of Attestation. The requirement for submission of a signed Letter of Attestation for Federal Fiscal Year 2007 has passed. There are providers of mh/dd/sa services who have not submitted their letters of attestation; thus claims will be denied. Once a provider number is

terminated no prior approval will be issued and existing prior approval will be terminated. No retroactive prior approval will be granted when this occurs.

Please visit the False Claim Act web page for more information at http://www.ncdhhs.gov/dma/fca/falseclaimsact.html. There you may access a searchable database to see if a provider must attest for the year. For additional questions contact EDS Provider Services at 1-800-668-6696 or 919-851-8888, option three.

2008 Community Support Medicaid Audits

The Accountability Team recently completed the 2008 Medicaid service audit of Community Support Services (both adult and child). This audit included paid claim service dates from April 1, 2008 to July 31, 2008 and was based on a random selection of all providers of Community Support Services. The number of providers included in the audit totaled 171. Providers were audited at eight sites across the State. Preliminary results from 164 of these providers, specific to the delivery of services, indicate the main compliance issues noted were:

- 65 of 164 providers (40 %) had issues associated with the question relating to the service being delivered in accordance with the service definition.
- 107 providers (65%) had issue with the question related to documentation needing to reflect treatment for the duration of the service billed.
- 109 providers (65%) were unable to verify that staff met qualification/training requirements necessary to provide the service.

From an overall, rather than provider specific perspective, 164 providers representing 2,460 dates of service audited.

- 175 (7%) of the dates audited were out of compliance with the question relating to the service being delivered in accordance with the service definition.
- 409 (17%) of the dates audited were out of compliance with the question related to documentation needing to reflect treatment for the duration of the service billed.
- 621 (25%) of the dates audited were out of compliance in regards to staff meeting qualification/training requirements necessary to provide the service. (Note: One staff member may have provided services on multiple service dates).

Accreditation Update

Providers who enrolled with DMA between March 20, 2006 and April 30, 2006, are now subject to the second benchmark outlined in Session Law 2008-107 (House Bill 2436). Any provider that enrolled during this time period that does not have an on-site accreditation review scheduled by the accrediting agency as documented by a letter from the accrediting agency will have their Medicaid enrollment and/or state funded contracts terminated. Within three months the following actions will occur:

1. The Local Management Entity (LME) will identify the provider(s) which did not meet the benchmark and submit a Notice of Endorsement Action (NEA). The NEA will establish the effective date of the withdrawal action which will be no later than three months from the date when the provider did not meet the six-month benchmark.
2. No new consumers may be admitted by the provider agency.
3. Providers must work with the LME to transfer the entire caseload served by the provider over a three-month period, in increments of at least 33% per month. Please note that the Records Management and Documentation Manual, which applies to Medicaid and state-funded services, requires providers to copy and provide to the new provider on a timely basis relevant clinical and consumer-specific information to ensure continuity of care. It is the responsibility of the LME to identify other providers to serve the consumers impacted by the accreditation action. The consumer has a choice of the providers identified by the LME. Any provider utilized for transition must be a provider who is in substantial compliance with the rules and regulations of the Department of Health and Human Services (DHHS) and the MOA, including meeting all applicable accreditation benchmarks.
4. Providers are responsible for maintaining the clinical and financial records of services provided for the duration of the disposition period as specified in the *Records Retention and Disposition Schedule for State Agencies and Area Facilities (APSM 10-3).* This requirement applies to providers whether or not the provider agency remains in business or is dissolved as a result of the withdrawal of endorsement. Furthermore, providers whose endorsement is withdrawn shall inform the LME in writing of where these records are stored.
5. The LME will make readily available to the public a list of providers that will be terminated as a result of failure to achieve satisfactory progress in gaining national accreditation and a list of providers available to provide services to consumers impacted by the pending termination.
6. The LME is required to monitor paid claims to ensure caseloads are transferred within the three month timeframe.

During this transition period, the provider receiving consumers should ensure that a clinical review of the assessment and Person Centered Plan for each consumer is completed. The LME should work with the provider to transfer authorizations for state-funded consumers and assist in coordinating with DHHS and ValueOptions to ensure a seamless transition.

These timeframes apply only to Accreditation Benchmark 2 (Six Months). Subsequent benchmarks are at three months, and the accreditation deadline. The actions that will be taken by the LME and by providers failing to meet the subsequent benchmarks will be similar but modified to reflect the different timeframes outlined in statute for those benchmarks.

The six month bench mark is applicable to those providers who enrolled with DMA between March 20, 2006 and April 30, 2006. However, the first accreditation benchmark outlined in Implementation Update #47 is now applicable to providers who enrolled with DMA between May 1, 2006 and June 30, 2006. Thus, LMEs will also be monitoring these provider agencies for compliance with Benchmark 1 (Nine Months).

Please note: A termination of a contract or Medicaid enrollment as a result of failure to meet a national accreditation benchmark is not appealable since these benchmarks are now the law in North Carolina.

CAP-MR/DD Update

DHHS is very pleased to announce the approval of the Supports waiver and the Comprehensive waiver, by the Centers for Medicaid and Medicare Services. DHHS received official notification of the approval of the waivers on October 27, 2008. We are on schedule to implement the new waivers effective November 1, 2008 as planned. We'd like to express our appreciation to everyone who has participated in the development and the implementation of the new waivers.

The DMH/DD/SAS has provided multiple statewide trainings over the past month regarding the specific components and operational details of the two new waivers (the Supports waiver and the Comprehensive waiver). Some operational details have been revised as we move closer to implementation. DMH/DD/SAS recognizes that such change creates potential confusion; however, revisions have been necessary to ensure operational details accurately reflect the intent and components of the new waivers. The presentation is posted on the Division of Mental Health, Developmental Disabilities and Substance Abuse Services website: www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm .

The DMH/DD/SAS has conducted weekly phone calls with the Local Management Entities in an effort to provide current and accurate information, to support their role and responsibility to provide information and to respond to questions from participants, families, providers and other interested community members. The DMH/DD/SAS will continue to have regular communication with the LMEs to provide updated information for distribution to participants, families and providers.

The following information is the most current and accurate information available regarding the operational details of the two new waivers. The DHHS will use future Implementation Updates to provide additional information.

Home Supports

There continues to be confusion regarding the new Home Supports definition. Home Supports is a service that will be delivered by biological parents, adoptive parents, step-parents, guardians of the person and other family members who live in the natural home with the participant. Home Supports is a blended service that combines habilitation (skill building and maintenance) and personal care. Home Supports can be provided by the biological parents, adoptive parents, step-parents, guardians of the person and other family members who live in the natural home with the participant. The service will have **five** levels of reimbursement, depending upon the needs of the participant and will be paid at a daily rate.

Participants whose biological parents, adoptive parents, step-parents, guardians of the person and other family members who live in the natural home with the participant and elect to provide services may also receive services from other caregivers; the family does not have to provide 100% of the service. On the same day the participant receives Home Supports, they may also receive any of the following services:

- Supported Employment
- Day Supports
- Long Term Vocational Supports
- Adult Day Health
- Individualized Day Program (community component of Home and Community Supports)
- A variety of other habilitation services that are not delivered in the home.

Since the service will be paid at a daily rate, biological parents, adoptive parents, step-parents, guardians of the person and other family members who live in the natural home with the participant, providing Home Supports and living with the adult participant will be responsible for providing all of the personal care and habilitation services the participant needs in the

home. A participant may receive Home Supports from their biological parents, adoptive parents, step-parents, guardians of the person and other family members who live in the natural home with the participant, one day and other services (Home and Community Supports and/or Personal Care) from another provider the next day. The appropriate combination of services will be determined by the participant and their biological parents, adoptive parents, step-parents, guardians of the person and other family members who live in the natural home with the participant working with their case manager in developing the Person Centered Plan/Plan of Care. In addition, the participant may also receive respite services in order to provide the biological parents, adoptive parents, step-parents, guardians of the person and other family members who live in the natural home with the participant relief from caregiver duties.

Family members who do not live in the same home with the participant will continue to be able to deliver any service for which they meet the staff qualifications. Family members who do not live in the home with the participant will not be able to deliver Home Supports.

Special Notice Regarding Transition to Home Supports
As DHHS has moved towards implementation of the new CAP-MR/DD waivers we are pleased to hear that many participants and families are satisfied with the new Home Supports definition; although, we have received feedback from some family members indicating that Home Supports doesn't provide the needed flexibility for their family member. Some families have indicated that Home Supports does not allow participants to receive services from parents and family members in a manner that support the flexibility needed to continue to provide care for participants in the family home. In an effort to allow and support participants and families to make the transition to the new Home Supports definition, DHHS has decided to allow those participants and families, who are experiencing difficulties with the transition to Home Supports, the opportunity to continue to receive/provide services as indicated in the authorized Plan of Care in effect prior to October 31, 2008, for up to 60 days or until January 1, 2009. This additional time for transition will allow DHHS time to consider the feedback and implications of the components of the Home Supports definition and determine if there are solutions to support flexibility while maintaining the financial integrity of the Home Supports definition and the federal requirements of the waivers.

Any participant/family who is **NOT** experiencing difficulties with the transition to Home Supports and chooses to may move forward with the transition based on the approved Plan of Care or Revision completed to be implemented November 1, 2008.

In the case of participants who choose to continue to receive/provide services as indicated in the authorized Plan of Care in effect ***prior to 10-31-08 (prior to the transition to Home Supports)***, and a Plan of Care Revision to add Home Supports has been submitted or approved by Value Options, a Plan of Care Revision will need to be completed to reflect this change effective November 1, 2008 through January 1, 2009.

Home Support, Level V
DHHS has made a decision to provide an additional level of support to the Home Support definition. The Home Supports definition now has five levels: Level I, Level II, Level III, Level IV and Level V. The Level V is intended to support participants who require in excess of 12 ½ hours per day of direct service. Direct service is considered Personal Care services, Home and Community Supports or a combination of both Personal Care and Home and Community Supports services.

In an effort to ensure all participants currently receiving 12 ½ hours of direct service continue to receive this level of service, the DHHS is working with the LMEs to secure participant specific information from case management agencies. This information will be provided to ValueOptions with specific participant information.

Utilization Guidelines
The *Utilization Guidelines* document is being revised to concur with the recent changes as outlined in this Implementation Update.

A Minimum of One Service Required Each Month
Participants must receive at least one direct service each month to be maintained on the CAP-MR/DD waivers. Direct service does **not** include case management, equipment or supplies. CAP-MR/DD eligible participants are determined to require ICF-MR Level of Care. This level of care indicates that a participant requires intensive services and supports to remain in the community. Case managers and Local Management Entities are required to monitor adherence to this requirement.

Habilitation Maximums
- Adults may receive up to 12 hours of habilitation per day. This includes the habilitation portion of Home Supports and Residential Supports.

- **Habilitation for Children**
  On days that school is in session
  - No CAP-MR/DD service may be utilized in school.
  - Any participant enrolled in public school or between 5-15 years of age can receive no more than six hours of habilitation a day when school is in operation, according to the calendar published by the Local Education Authority (LEA).
  - If the IEP indicates that the time the participant is in school is less than the standard school session each day, only CAP/MR-DD non-habilitative services such as Personal Care Services or the Personal Care component of Residential Supports may be used for the remainder of the school day session.
  - Children may receive three hours of CAP-MR/DD habilitative services and an additional three hours of CAP-MR/DD habilitative services may be approved, if clearly justified.
  - No CAP-MR/DD habilitation services may be utilized during the time that school is typically in session.

  On days that school is not in session
  - Children may receive nine hours of CAP-MR/DD habilitation during a non-school day. An additional three hours of CAP-MR/DD habilitation, may be approved, if clearly justified**.**

If a child is receiving between 9-12 hours of habilitative services per day the case manager should be working with the team to determine if the three hours (above the six allowable hours) are justified in the Plan of Care and can address (make any needed revisions) it at the next CNR time. If the child is receiving beyond the 12 hours of habilitative services **per day** a revision needs to be completed immediately to decrease the hours to ensure compliance to the requirement.

Children who are home schooled follow the same guidelines as children who are in public school.

Transition Requirements for New and Modified CAP-MR/DD Services
This serves to provide additional information to supplement the information contained in Implementation Update #49, regarding transition requirements and processes for existing providers to be eligible to provide the new service definition, Home Supports.

1. ***Existing*** providers of Residential Supports, **OR** Home and Community Supports**, OR** Personal Care services, who intend to provide Home Supports.
   - The provider sends the signed ***CAP-MR/DD Letter of Attestation,*** *and the completed DMA Addendum Application to DMA, Provider Services.*

   AND
   - The provider sends the original signed ***CAP-MR/DD Letter of Attestation*** to the LME located in the catchment area where the provider's corporate office is located, and a copy to all LMEs with whom there is a signed MOA.

The LME located in the catchment area where the provider's corporate office is located, is required to complete a monitoring review **(using the Home Supports Endorsement Checksheet and Instructions),** of these providers within **60 days** of the implementation of the waivers or provider delivery of the service, to ensure compliance to the requirements of the Home Supports definition.

2. ***Existing*** providers of CAP-MR/DD services, other than Residential Supports, Home and Community Supports, and Personal Care Services, who currently employ parents, family members and/or guardians who provide paid support to their adult child CAP-MR/DD participant.
   - The provider sends the signed *CAP-MR/DD Letter of Attestation II (attached) and the completed DMA Addendum Application to DMA, Provider Services.*

   AND
   - The provider sends the original signed *CAP-MR/DD Letter of Attestation II* to the LME located in the catchment area where the provider's corporate office is located, and a copy to all LMEs with whom there is a signed MOA.

   The LME located in the catchment area where the provider's corporate office is located, is required to complete a monitoring review **(using the Home Supports Endorsement Checksheet and Instructions)** of these providers ***within 30 days*** of the implementation of the waivers or provider delivery of the service, to ensure compliance to the requirements of the Home Supports definition.

3. ***Existing p*****roviders,** who intend to continue to provide, any of the modified service definitions (Adult Day Health, Crisis Services, Day Supports, Home and Community Supports, Personal Care, Residential Supports, Respite, Supported Employment) are required to:

- Send the original signed *CAP-MR/DD Letter of Attestation* to the LME located in the catchment area where the provider's corporate office is located.

AND

- Send a copy to all LMEs with whom there is a signed MOA.

The LMEs are required to complete a monitoring review of these providers within **60 days** of the implementation of the waivers or provider delivery of the service, to ensure compliance to the new requirements.

This information is also contained in the attached document titled, ***Transition Requirements for New and Modified CAP-MR/DD Services.***

New providers of all CAP-MR/DD services are required to complete endorsement and enrollment per the DHHS *Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services.*

Staff Training/Qualifications

All the CAP-MR/DD service definitions contain specific staff training/core competencies and staff qualification requirements. The core competencies are posted on the DMH/DD/SAS website, www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm. All staff providing CAP-MR/DD services are required to have training specific to the core competencies effective November 1, 2008 and prior to delivery of services. All staff are required to have First Aid and CPR training/certification effective November 1, 2008 and prior to delivery of services. All staff are required to have a high school diploma or GED. Existing staff have up to 18 months to secure a high school diploma or GED. Any staff hired November 1, 2008 forward, are required to have a high school diploma or GED at hire and prior to delivery of services.

Staff Qualifications

The CAP-MR/DD service definitions contain the following requirement: "Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline." This means that associate professionals may no longer supervise paraprofessionals. Paraprofessionals and associate professionals must be supervised by qualified professionals. This requirement is effective November 1, 2008.

Plan of Care Revisions and Continued Need Reviews (CNRs) to Add New Services

Due to the time frame required for endorsement and enrollment for the new CAP-MR/DD services, case managers completing CNR s and revisions should ensure that the implementation date for the new services project out at least 90 days on the cost summary. This will allow providers adequate time to secure endorsement and to enroll with DMA, provide a smooth transition between services as well as ensure participants do not lose services currently being provided. If a participant's Plan of Care (POC) has already been submitted to ValueOptions, with an authorization request for LTVS to be effective November 1, 2008 we will develop a process to amend the POC to allow continued access for supported employment to continue, as appropriate, during this transition period.

New Manuals for the Supports Waiver and the Comprehensive Waiver

The Division of MH/DD/SAS and DMA are working to develop the new manuals for the Supports waiver and the Comprehensive waiver. This information will be released December 15, 2008.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
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Attachment